CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
PHASE II UPDATE

In June 2002, the Department of Veterans Affairs (VA) announced that the second phase of VA's national planning process, designed to meet the health care needs of veterans over the next 20 years, was underway. Capital Asset Realignment for Enhanced Services (CARES) was first conducted as a pilot study in Veterans Integrated Service Network 12. (VA's medical system is divided into 21 regional health care Networks.) Phase II is being conducted in the remaining 20 Networks.

Once CARES is completed, VA will have a national plan for directing resources where they are most needed; preserving VA's missions and special services; and continuing to provide high-quality care to more veterans in more locations.

To ensure consistency, the CARES process will be standardized throughout VA's health care system, using the following steps:

- Defining a veteran population base;
- Defining health care Market Areas;
- Determining the demand for future health care services and space needed to provide those services through the next 20 years by Market Areas;
- Determining the current supply of health care services by Market Areas; and
- Identifying Planning Initiatives that will evolve into Market Plans for each of VA's Networks.

DATA ON VETERANS

To begin the process, Networks first defined a "veteran enrollment base" using the following data and information:

1. The number of veterans:
   a. enrolled to receive VA health care and who are currently receiving care,
   b. enrolled but *not* currently receiving care, and
   c. *not* enrolled and currently receiving care; and
2. Projections on veteran enrollment for VA health care.

MARKET AREAS

In July, each Network completed the process of defining Market Areas. Market Areas are the geographic areas or boundaries (by county or zip code) served by that Network's medical facilities. A Market Area is of a sufficient size and veteran population to benefit from coordinated planning and to support the full continuum of health care services (inpatient, outpatient, mental health and long-term care).

Market Area definitions also may have been influenced by state and county borders, geographic barriers (e.g., mountains), as well as distance and travel times to a VA facility. In defining them, Networks also estimated the percentage of enrollees within specified travel times to a VA facility. The travel time estimates for populations of veterans took into consideration the type of care (inpatient vs. outpatient care) and location (urban, rural or highly rural). Networks sharing coverage for a geographic area jointly determined lead planning responsibility for the area.

Some Networks also identified Submarkets within Market Areas. Submarkets might be based on clusters of veterans (in urban areas, for example), or based on the demand for services, or the history of use and the geographic location. A Market will be able to support a full continuum of care; a Submarket is not likely to provide the full range of VA health care services.

DEMAND FOR VA HEALTH CARE

Projections for the future demand for VA health care is key to identifying any gaps in services and developing Planning Initiatives. This step will quantify future demand in each Market and Submarket through the next 20 years. Predicted demand for care will be based on current use of VA health care services at both the Market and Submarket levels as projected over the next 20 years. As part of this analysis, determinations also will be made of the space needed to provide these services.

SUPPLY OF VA HEALTH CARE SERVICES

In addition to data on veteran enrollees, a profile is being created of each VA health care facility within each Network. The information includes:

1. Condition of buildings
2. Identification of vacant or underused space
3. Seismic issues
4. Identification of enhanced-use opportunities
5. Current programs and services offered
6. Employment data
7. Costs

8. Medical school affiliations
9. Research programs

In analyzing the supply of clinical services, Network Strategic Plans also will be considered, as well as the availability of Department of Defense (DoD) health care services, other sharing activities and the availability of community medical resources (to identify the potential for partnerships, collaborations or contracting opportunities).

The information on programs and services will be combined with projected demand and space data in identifying Planning Initiatives for each Market Area.

PLANNING INITIATIVES

The next step will be to use the information and analyses from the earlier stages of the CARES process in order to identify gaps (or redundancies) between the supply and current locations of VA health care services and the projected needs of veterans. Future demand within the defined Market Areas (by Market, Submarket and facility) will be analyzed for 2012 and 2022.

This step will be conducted by the National CARES Program Office (NCPO). As part of this analysis, underserved veteran populations will be identified, as well as facilities with low demand or duplications in services in areas where VA facilities are in close proximity to one another. The NCPO will analyze where gaps exist in the Network as a whole and within each Market. These analyses will form the basis of Planning Initiatives. Adjustments will be made to address the special needs of veterans, such as blind and spinal cord injury rehabilitation, long-term care and alternatives to institutional long-term care. Other key issues, such as Homeland Security and enhanced use opportunities, also will be considered. In addition, expanding or enhancing sharing opportunities with DoD will be identified, as well as possible collocations or space planning with the Veterans Benefits Administration and the National Cemetery Administration.

Once identified, Planning Initiatives will be forwarded to Networks for review and completion. Networks will then develop various solutions that address the gaps or duplications identified in the Planning Initiatives to ensure that health care resources are aligned to meet future patient demand in the most appropriate locations. For each Planning Initiative, Networks will conduct a cost-analysis and assess each Planning Initiative using CARES planning criteria.

Networks also may develop recommendations for additional Planning Initiatives to propose to the NCPO. The NCPO will review the completed Planning Initiatives with the Networks. Network Market Plans will evolve from these completed Planning Initiatives and will be incorporated into the draft National CARES Plan.

Once approved by the Under Secretary for Health, an independent CARES Commission will evaluate the draft National CARES Plan, which also will be published for public comment. As part of its review, the CARES Commission will solicit input from stakeholders, consider comments received during the 60-day public comment period and hold public hearings. Following its review and evaluation, the Commission will forward its recommendations to the Secretary of Veterans Affairs, who will make his decision on the National CARES Plan in late 2003.

STAKEHOLDER FEEDBACK

Stakeholder outreach and feedback are important parts of the CARES process. Briefings will be conducted at both the national and local levels at each stage of CARES Phase II. Stakeholder input will be solicited and considered in the development of Planning Initiatives and Market Plans, during the public comment period and at CARES Commission hearings.

For more information on CARES, contact the nearest VA medical center or visit the CARES Web site at www.va.gov/CARES.

QUESTIONS AND ANSWERS ON MARKET AREAS

Q: What are the data sources VA is using in CARES?

A: For CARES Phase II, VA is using a variety of data sources, including:

1. Projections from the adjusted 1990 Census data;
2. Military separations and projected separations (using the Defense Department's actuarial model);
3. VA's Compensation and Pension file. This file identifies veterans with disabilities and can help determine migration patterns (studies show that veterans are twice as mobile compared with the general population as a whole); and
4. Enrollee projections (prepared by an outside contractor). Current and projected enrollee data will be analyzed by county (or zip code for urban areas, for example), age group and enrollment categories.

Q: Is VA using any data from Census 2000?

A: Currently, the veteran-related Census 2000 data provided (in June 2002) are not available in sufficient detail to use for CARES-related planning purposes. For example, no information is yet available by age, sex or period of service – data VA needs for health care planning. The 1990 data will be modified or adjusted to take into account changes identified in the Census 2000 data. Census 2000 data will be incorporated when it becomes available in 2003.

Q: How will VA project data on veteran enrollment for VA health care?

A: Enrollment projections are based on trends in the number of veterans enrolling for care in the VA health care system over the past three years. The enrollment projections are compared with veteran population projections, and adjustments are made based on the number of new veterans (Department of Defense separation projections) and mortality experience. It should be noted that not all veterans enrolled for VA health care actually use VA for their health care needs.

Q: Which Market Areas were defined by zip code?

A: In general, any county with a projected enrollee population for FY 2010 of more than 30,000 required a zip code analysis to determine the demand for care. In addition, Markets that require dividing a county boundary used a zip code analysis.

Q: In defining Market Areas, did VA include veterans enrolled in all categories for VA health care or only the top priority categories?

A: No distinctions were made among the priority categories.

Q: What are the possible alternative uses for buildings that are determined to be excess or unsuitable for the delivery of modern health care?

A: One possibility is an enhanced-use lease. An enhanced-use lease is a VA-private sector joint business venture that benefits both parties. These leases provide VA with an economical way to acquire goods, services and facilities at reduced cost. In such an arrangement, typically underused or excess VA property is leased to the private sector for a nominal rent. The private sector then finances and develops the property for a profitable non-VA venture. In return, VA receives substantial discounts, facilities, services and/or revenue.

An example is the plan for an enhanced-use lease for a privately financed, developed and managed office and parking garage complex on the grounds of the West Side Division of the VA Chicago Healthcare System. The project will provide VA with access to parking spaces for veterans (at no charge), volunteers, visitors and staff.

Q: Will VA analyze the demand for special veterans' programs, such as spinal cord injury and blind rehabilitation?

A: Yes. VA also will analyze the demand for programs, based upon capacity requirements, in substance abuse, traumatic brain injury, homelessness, seriously mentally ill veterans and post-traumatic stress disorder. As required by law, current special programs will not be reduced.

Q: What are the criteria to be used in evaluating Planning Initiatives?

A: The criteria are:

1. Health care quality and need (whether the initiatives impact on the quality of care and whether the initiatives meet the identified gaps in services);
2. Safety and environment of care;
3. Appropriate access to care (travel time);
4. Impact on research and education programs;
5. Impact on employees and communities;
6. Impact on community health care providers;
7. Support of other VA missions (VA-DoD collaboration, collocation with other VA administrations, VA's contingency role as medical backup to DoD, VA's role in Homeland Security and emergency preparedness); and
8. Optimizing the use of VA resources (cost-effectiveness, "right sizing" and realigning facilities based on future demand and needs).